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Sexual and reproductive health and rights of girls and young women with disabilities

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the rights of persons with disabilities, Catalina Devandas Aguilar, submitted in accordance with Human Rights Council resolution 35/6.

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Report of the Special Rapporteur on the rights of persons with disabilities

Summary

In the present report, the Special Rapporteur on the rights of persons with disabilities examines the challenges experienced by girls and young women with disabilities in relation to their sexual and reproductive health and rights, and provides guidance to States on how to ensure legal and policy frameworks that support their autonomy and address the structural factors that expose them to violence, abuse and other harmful practices.

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I. Introduction

1. In its resolution 35/6, the Human Rights Council requested the Special Rapporteur of the Human Rights Council on the rights of persons with disabilities to report annually to the General Assembly.

2. In her thematic reports, the Special Rapporteur has underscored the importance of ensuring a gender perspective in all interventions related to persons with disabilities, stressing the significant additional barriers that women and girls with disabilities encounter that can prevent them from the full enjoyment of their rights. As international and national efforts on the rights of persons with disabilities have too often failed to take into account a gender perspective, it is urgent that the multifaceted discrimination, marginalization and compounded human rights violations that women and girls with disabilities face in most societies be addressed (see A/HRC/28/58, para. 19 (d)).

3. The present report focuses on the sexual and reproductive health and rights of girls and young women with disabilities. The term "girls with disabilities" refers to women with disabilities below the age of 18 years, whereas the term "young women with disabilities" refers to women between 15 and 24 years of age.[1] The Special Rapporteur stresses that those women face significant challenges in making autonomous decisions with regard to their reproductive and sexual health, and are regularly exposed to violence, abuse and harmful practices, including forced sterilization, forced abortion and forced contraception. She recalls that States have an obligation to invest in the sexual and reproductive health and rights of girls and young women with disabilities, and to end all forms of violence against them.

4. In preparing her report, the Special Rapporteur analysed 47 responses to a questionnaire sent to Member States, national human rights institutions and civil society organizations, including representative organizations of persons with disabilities, as well as the outcome of consultations conducted with girls and young women with disabilities in three countries, whose main trends are reflected in the text. She also organized an expert consultation in New York in June 2017 with representatives of United Nations agencies, women's organizations and organizations of persons with disabilities. The Special Rapporteur would like to thank Plan International, who supported the research efforts for the study, which was undertaken under the coordination of her office.

II. Sexual and reproductive health and rights of girls and young women with disabilities

A. Context

5. There are more than one billion people with disabilities in the world today, and the average global disability prevalence rate is estimated to be 15.6 per cent.[2] Persons with disabilities experience great social disadvantages worldwide, such as poverty; discriminatory laws and practices; environmental and information barriers; poor education, health and employment; and increased expenditures related to the extra cost of living with a disability (see A/70/297, paras. 25-32, and A/71/314, paras. 13-16).

[1] See Convention on the Rights of the Child, art. 1, and *United Nations System-wide Action Plan on Youth Report* (2014), p. 5. Available from www.unyouthswap.org/system/refinery/resources/2014/10/15/20_42_35_106_UN_Youth_SWAP_Report_2014.pdf.

[2] World Health Organization (WHO) and World Bank, *World Report on Disability* (Geneva, 2011), p. 27. Available from www.who.int/disabilities/world_report/2011/en.

6. Disability is more prevalent among women than men. Women with disabilities account for almost one fifth of the world's female population.[3] There are no reliable and representative global data on children with disabilities.[4] Estimates suggest that there are between 93 and 150 million children with disabilities worldwide, but numbers could be higher.[5] Furthermore, there are very few statistics available on girls with disabilities at national and international levels, as generally data are not disaggregated by gender, age and disability. That scarcity of data has contributed to making the pressing human rights issues that affect children with disabilities, and girls in particular, invisible.

7. The intersection between young age, disability and gender results in both aggravated forms of discrimination and specific human rights violations against girls and young women with disabilities. While in all parts of the world persons with disabilities are faced with violations of their rights and barriers to their participation as equal members of society, girls with disabilities are significantly worse off than boys with disabilities, regardless of the types and levels of impairment. Girls with disabilities are more likely to be excluded from family interactions and activities, and are less likely to have access to education, vocational training and employment, or to benefit from full inclusion.[6]

8. Furthermore, girls and young women with disabilities are, almost without exception, prevented from making autonomous decisions with regard to their reproductive and sexual health, which can result in highly discriminatory and harmful practices, as discussed in section III below. Many of those practices occur in institutions, as girls and young women with disabilities are more likely to be institutionalized.[7]

B. Disability and sexual and reproductive health and rights

9. For women with disabilities, disability inclusion and gender equality cannot be achieved without addressing their sexual and reproductive health and rights. In particular, girls and young women with disabilities are able to develop their own identities and realize their full potential when their sexual and reproductive health needs and rights are met. That contributes to ensuring their health and well-being, reducing the existing gaps in their access to education and employment and achieving their empowerment. When those needs and rights are not met, they are exposed to unintended pregnancies, sexually transmitted diseases, gender-based violence and sexual abuse, child marriage and other harmful practices that hamper their participation.

10. Sexual and reproductive health and rights are human rights. They are not only an integral part of the right to health, but are necessary for the enjoyment of many other human rights, including the rights to life, freedom from torture and ill-treatment, freedom from discrimination, equal recognition before the law, privacy and respect for family life, education and work. As such, sexual and reproductive health and rights are universal and inalienable, indivisible, interdependent and interrelated. States must ensure the availability,

[3] WHO and World Bank, *World Report on Disability*, p. 28.

[4] C. Cappa, N. Petrowski and J. Njelesani, "Navigating the landscape of child disability measurement: a review of available data collection instruments", *ALTER, European Journal of Disability Research*, vol. 9, No. 4 (October-December 2015).

[5] WHO and World Bank, *World Report on Disability*, p. 36.

[6] *The State of the World's Children: Children with Disabilities* (United Nations publication, Sales No. E.13.XX.1), p. 1. Available from www.unicef.org/sowc2013/files/SWCR2013_ENG_Lo_res_24_Apr_2013.pdf.

[7] United Nations Children's Fund (UNICEF), "Children and young people with disabilities", fact sheet, May 2013, p. 19. Available from www.unicef.org/disabilities/files/Factsheet_A5__Web_NEW.pdf.

accessibility, acceptability and quality of facilities, goods, information and services related to sexual and reproductive health and rights.[8]

11. Sexual and reproductive health and rights entail a set of freedoms and entitlements. They encompass the right to have control over decisions concerning sexuality and reproduction without discrimination, coercion and violence, and the right to access a range of sexual and reproductive health facilities, services, goods and information.[9] Sexual and reproductive health services include, inter alia, contraceptive counselling, information, education, communication and services; education and services for prenatal care, safe delivery and postnatal care; the prevention and appropriate treatment of infertility; safe abortion services; the prevention and treatment of sexually transmitted and reproductive tract infections; and sexual and reproductive health information, education and counselling (see A/CONF.171/13/Rev.1, chap. VII).

12. States have an obligation to respect, protect and fulfil the sexual and reproductive health and rights of girls and young women with disabilities. The International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of Persons with Disabilities, as well as other international and regional instruments, outline standards for securing the sexual and reproductive health and rights of girls and young women with disabilities and for protecting their right to be free from any kind of gender-based violence.

13. Sexual and reproductive health, human rights and sustainable development are all interconnected. The Sustainable Development Goals explicitly call for ensuring "universal access to sexual and reproductive health and reproductive rights", and include targets related to that under Goal 3, Ensure healthy lives and promote well-being for all at all ages; Goal 4, Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; and Goal 5, Achieve gender equality and empower all women and girls. In addition, Goal 5 stresses that all forms of discrimination and violence against girls and women (including those with disabilities) must be eliminated. Investing in sexual and reproductive health and rights saves lives and empowers girls and young women with disabilities. Protecting and promoting their sexual and reproductive health and rights should therefore be a top priority for States.

C. Convention on the Rights of Persons with Disabilities

14. The adoption of the Convention on the Rights of Persons with Disabilities represented a major milestone towards the full and effective enjoyment of sexual and reproductive health and rights by girls and young women with disabilities. Embracing the basic principles of human rights, the Convention moves away from medical and paternalistic approaches towards a human rights-based approach to the sexual and reproductive health and rights of persons with disabilities. The Convention challenges all forms of substituted decision-making in the exercise of sexual and reproductive health and rights (see arts. 12 and 25); prohibits harmful and discriminatory practices against persons with disabilities in all matters related to marriage, family, parenthood and relationships, including the right to retain their fertility and to decide on the number and spacing of their children (see art. 23); calls to end all forms of exploitation, violence and abuse, including their gender-based aspects (see art. 16); and promotes access to quality sexual and affordable reproductive health care and programmes (see art. 25).

[8] See Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, paras. 11-21.

[9] Ibid., para. 5; E/CN.4/2004/49, paras. 22-40.

15. The Convention addresses the rights of girls and women with disabilities in a cross-cutting manner, adopting a twin-track approach. On one hand, it includes specific articles on women and children with disabilities (see arts. 6 and 7); on the other, it refers to them in the general principles and other substantive articles (see arts. 3, 4, 8, 13, 16, 18, 23, 25 and 30). Article 6 recognizes that women and girls with disabilities are subject to multiple discriminations and requires States to adopt measures to ensure their full and equal enjoyment of rights, as well as their full development, advancement and empowerment. States must systematically mainstream the interests and rights of girls with disabilities in and across all national action plans, strategies and policies concerning women, childhood and disability, as well as in their sectoral plans. They must also target and monitor action aimed specifically at girls with disabilities, including their sexual and reproductive health and rights.[10]

16. Article 7 of the Convention provides that States must take measures to ensure the full enjoyment of rights by children with disabilities, consider the principle of best interests and respect their evolving capacities. The Convention requires States to ensure that boys and girls with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right (see art. 7, para. 3). The Convention thus reinforces the obligations of States to recognize and respect the evolving capacities of children with disabilities and to provide support to strengthen their capacities to enable independent decision-making. As stressed by the Committee on the Rights of the Child, the young age or the disability of a child does not deprive her or him of the right to express her or his views, nor reduces the weight given to the child's views in determining her or his best interests.[11]

17. While attention to the sexual and reproductive health and rights of girls and women with disabilities increased following the Programme of Action of the International Conference on Population and Development of 1994 and the Beijing Declaration and Platform for Action of 1995, it is in the Convention on the Rights of Persons with Disabilities that States and the international human rights system restated their commitment to promote and protect the rights of girls and young women with disabilities in that area. For example, the Committee on Economic, Social and Cultural Rights issued a general comment on the right to sexual and reproductive health with specific references to persons with disabilities, including accessibility and reasonable accommodation.[12] The Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child have also highlighted the importance of ensuring sexual and reproductive health services and ending sexual violence and harmful practices against women and girls with disabilities.[13] The special procedures of the Human Rights Council have also addressed the issue of sexual and reproductive health and rights of girls with

[10] See Committee on the Rights of Persons with Disabilities, general comment No. 3 (2016) on women and girls with disabilities, para. 27.

[11] See Committee on the Rights of the Child, general comment No. 14 (2013) on the right of a child to his or her best interests taken as a primary consideration, para. 54.

[12] See Committee on Economic, Social and Cultural Rights, general comment No. 22, paras. 2, 8-9, 16, 19-20, 24 and 30.

[13] See Committee on the Rights of the Child, general comment No. 20 (2016) on the implementation of the rights of the child during adolescence, paras. 31-32, Committee on the Elimination of Discrimination against Women and Committee on the Rights of the Child, joint general recommendation No. 31/general comment No. 18 on harmful practices, paras. 9 and 88, Committee on the Rights of the Child, general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, paras. 1, 5, 8, 15, 22 and 114 (b), Committee on the Rights of the Child, general comment No. 13 (2011) on the right of the child to freedom from all forms of violence, paras. 8, 15 (a), 16, 21 (e), 23, 41 (a), 43 (a) (ii), 47 (a) (i), 48, 54 (b), 56, 60, 72 (g) and 75 (a), and Committee on the Rights of the Child, general comment No. 3 (2003) on HIV/AIDS and the rights of the child, paras. 6, 9, 17, 21 and 37.

disabilities, including recent reports by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health with regard to the rights of adolescents (see A/HRC/32/32, paras. 86 and 94), the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment focused on torture in health-care settings (see A/HRC/22/53, paras. 48 and 57-70), the Special Rapporteur on violence against women, its causes and consequences, with regard to violence against women with disabilities (A/67/227) and the Working Group on the issue of discrimination against women in law and in practice focused on the issue of discrimination against women with regard to health and safety (see A/HRC/32/44, paras. 45-47).

III. Challenges of sexual and reproductive health and rights of girls and young women with disabilities

A. Stigma and stereotypes

18. Stigma and stereotypes play a significant role in limiting the sexual and reproductive health and rights of girls and young women with disabilities.[14] The sexuality of persons with disabilities is usually considered a taboo topic. Relatives, teachers and health-care providers are generally anxious, untrained and unconfident about discussing sexuality with them.[15] Moreover, there is a prevalent assumption that persons with disabilities, particularly girls and young women with disabilities, are either asexual or hypersexual.[16] Those stigmas are particularly strong in the cases of persons with intellectual and psychosocial disabilities. Empirical studies show, however, that young people with disabilities have the same concerns and needs with regard to sexuality, relationships and identity as their peers, and have similar patterns of sexual behaviour.[17]

19. Stereotypes based on gender and disability often lead to structural or systemic discrimination against women with disabilities, in particular when exercising their sexual and reproductive health and rights.[18] Stigma and misconceptions about disability and sexuality can have a profound negative impact on their lives and can lead to their disempowerment and infantilization. The nature of the prejudice experienced affects their self-esteem, making them feel insecure and socially isolated.[19] Girls and young women with disabilities are neither seen to be in need of information about their sexual and reproductive health and rights and available services, nor seen as competent to make decisions about their sexual and reproductive lives. Moreover, as many girls and young women with more severe impairments live at home or in institutions, often completely dependent on or controlled by others, they are denied the full exercise of their autonomy and privacy, whether that is intentional or not. Consequently, many girls and young women with disabilities lack the basic knowledge and support required to protect

[14] Office of the United Nations High Commissioner for Human Rights (OHCHR), "OHCHR commissioned report: gender stereotyping as a human rights violation", October 2013. Available from www.ohchr.org/Documents/Issues/.../2013-Gender-Stereotyping-as-HR-Violation.doc.

[15] M. Ballan, "Parental perspectives of communication about sexuality in families of children with autism spectrum disorders", *Journal of Autism and Developmental Disorders*, vol. 42, No. 5 (May 2012); A. Dupras and H. Dionne, "The concern of parents regarding the sexuality of their child with a mild intellectual disability", *Sexologies*, vol. 23, No. 4 (October-December 2014).

[16] See Committee on the Rights of Persons with Disabilities, general comment No. 3, para. 30.

[17] E. Brunnberg, M. L. Boström and M. Berglund, "Sexuality of 15/16-year-old girls and boys with and without modest disabilities", *Sexuality and Disability*, vol. 27, No. 3 (September 2009); A. C. B. Maia, "Vivência da sexualidad a partir do relato de pessoas com deficiência intellectual", *Psicologia em Estudo*, vol. 21, No. 1 (2016).

[18] See Committee on the Rights of Persons with Disabilities, general comment No. 3, para. 17 (e).

[19] M. M. Cheng and J. R. Udry, "Sexual behaviors of physically disabled adolescents in the United States", *Journal of Adolescent Health*, vol. 31, No. 1 (July 2002).

themselves from sexual abuse, unwanted pregnancy and sexually transmitted infections, and are not equipped to make informed decisions about their own bodies, health and lives.[20]

20. Dominant patriarchal assumptions of a woman's role as primarily that of a wife and mother also hinder girls and young women with disabilities from living healthy sexual and reproductive lives. Because girls and young women with disabilities are perceived to be less likely to become, or be capable of becoming, spouses, mothers or caregivers, families often pay less attention to them than to other family members, thereby deepening gender inequalities.[21] Likewise, the prevalent societal idea of beauty affects many girls and young women with disabilities, who see themselves as unattractive and unworthy. The prevalence of such models and views can have a deeply rooted impact on girls and young women with disabilities, as they may perceive themselves as incapable of fulfilling those models and views, creating a hard-to-break cycle of low expectations and relegation by their families and society. Some young women with disabilities report that stigma about disability makes them willing to accept a partner who might mistreat them.[22]

21. Girls and young women with disabilities belonging to groups that have been historically disadvantaged or discriminated against, such as indigenous peoples, religious and ethnic minorities, poor or rural populations, migrants and refugees, and lesbian, gay, bisexual, transgender and intersex persons, experience multiple and intersectional forms of discrimination in the exercise of their sexual and reproductive health and rights. For example, indigenous girls and women with disabilities face a higher risk of experiencing early marriage, sexual violence and unwanted pregnancy.[23] Girls with disabilities, particularly those with intellectual disabilities, also encounter significant barriers to asserting their sexual orientation because parents and guardians often deny and supress their views.[24]

22. Girls and young women with multiple impairments and those who are deaf, deaf-blind, autistic or have leprosy or an intellectual or psychosocial disability, experience aggravated forms of stigma and discrimination. For example, the pervasive view that girls and young women with intellectual disabilities lack the capacity to understand sexuality and their own bodies, as well as the fear of their relatives of being held responsible for allowing their sexual activity, puts those girls and young women under excessive monitoring and control. Furthermore, in some countries, girls and young women with disabilities, especially those with albinism, are at heightened risk of sexual violence owing to the myth that having sex with them can cure HIV/AIDS (see A/71/255, para. 17).

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[20] S. Altundağ and N. Ç. Çalbayram, "Teaching menstrual care skills to intellectually disabled female students", *Journal of Clinical Nursing*, vol. 25, Nos. 13-14 (July 2016); M. Á. A. Rodríguez, A. A. Díaz and B. A. Martínez, "Eficacia de un programa de educación sexual en jóvenes con discapacidad intellectual", *Análisis y Modificación De Conducta*, vol. 32, No. 142 (2006); J. Duh, "Sexual knowledge of Taiwanese adolescents with and without visual impairments", *Journal of Visual Impairment and Blindness*, vol. 94, No. 6 (2000).

[21] K. F. Linton and H. A. Rueda, "Dating and sexuality among minority adolescents with disabilities: an application of sociocultural theory", *Journal of Human Behavior in the Social Environment*, vol. 25, No. 2 (January 2015); J. A. McKenzie, "Disabled people in rural South Africa talk about sexuality", *Culture, Health and Sexuality*, vol. 15, No. 3 (2013).

[22] P. Chappell, "How Zulu-speaking youth with physical and visual disabilities understand love and relationships in constructing their sexual identities", *Culture, Health and Sexuality*, vol. 16, No. 9 (2014).

[23] Inter-Agency Support Group on Indigenous Peoples' Issues, "Thematic paper on sexual and reproductive health and rights of indigenous peoples", 2014.

[24] L. Löfgren-Mårtenson, "The invisibility of young homosexual women and men with intellectual disabilities", *Sexuality and Disability*, vol. 27, No. 1 (March 2009).

B. Barriers to accessing information and services on sexual and reproductive health and rights

23. Many girls and young women with disabilities do not have access to information and education about sexual and reproductive health and rights and related services. Several studies found that youth with disabilities, especially girls and young women with intellectual disabilities, have low levels of sexuality education and sexual and reproductive health and rights knowledge, including information with regard to the prevention and transmission of HIV.[25] The lack of inclusive education prevents girls and young women with disabilities from accessing comprehensive sexuality education, as those programmes are usually not available in special education settings. In addition, comprehensive sexuality education is not always delivered in accessible formats and alternative languages, and very often it does not address disability-specific needs.[26] Stigma and stereotypes about female sexuality can also lead to the exclusion of girls and young women with disabilities from existing comprehensive sexuality education programmes by their parents, guardians and teachers.[27] There is a general lack of guidance for families and teachers on how to talk about sexuality and equality with girls and young women with disabilities.

24. Furthermore, in many parts of the world, girls and young women with disabilities are often entirely excluded from the education system, or otherwise isolated from their communities at home or in institutions, and are without any access to sexuality education. The lack of equal access to inclusive and quality education affects, in particular, girls and young women with disabilities in conflict, post-conflict or other humanitarian situations, especially those who are refugees, internally displaced, migrants or asylum seekers; deprived of their liberty in hospitals, residential institutions, juvenile or correctional facilities; or homeless or living in poverty. Girls and young women in such situations are at heightened risk of being subjected to physical or sexual abuse and contracting sexually transmitted infections.[28]

25. Girls and young women with disabilities frequently have limited access to sexual and reproductive health-care services. Common barriers to accessing those services include negative and hostile attitudes among service providers; the absence of physical accessibility with regard to buildings and equipment (e.g., exam tables and diagnostic equipment); the lack of information in accessible formats (e.g., in Braille or plain language); communication barriers (e.g., the lack of training for service providers on communicating with young women and girls with intellectual disabilities and the inability to use sign language); relatives and caregivers acting as gatekeepers to information and services; the lack of accessible transportation to or from services; the affordability of

[25] T. Alemu and M. Fantahun, "Sexual and reproductive health status and related problems of young people with disabilities in selected associations of people with disability", *Ethiopian Medical Journal*, vol. 49, No. 2 (April 2011); A. Jahoda and J. Pownall, "Sexual understanding, sources of information and social networks: the reports of young people with intellectual disabilities and their non-disabled peers", *Journal of Intellectual Disability Research*, vol. 58, No. 5 (May 2014).

[26] C. Alquati Bisol, T. M. Sperb and G. Moreno-Black, "Focus groups with deaf and hearing youths in Brazil: improving a questionnaire on sexual behavior and HIV/AIDS", *Qualitative Health Research*, vol. 18, No. 4 (April 2008); C. Krupa and S. Esmail, "Sexual health education for children with visual impairments: talking about sex is not enough", *Journal of Visual Impairment and Blindness*, vol. 104, No. 6 (2010).

[27] A. Lafferty, R. McConkey and A. Simpson, "Reducing the barriers to relationships and sexuality education for persons with intellectual disabilities", *Journal of Intellectual Disabilities*, vol. 16, No. 1 (March 2012); S. Mall and L. Swartz, "Attitudes toward condom education amongst educators for deaf and hard-of-hearing adolescents in South Africa", *African Journal of Primary Health Care and Family Medicine*, vol. 6, No. 1 (August 2014).

[28] Handicap International, "Disability in humanitarian context: views from affected people and field organisations", Study — 2015, Advocacy (2015), p. 9. Available from www.handicap-international.org.uk/sites/uk/files/documents/files/2015-07-study-disability-in-humanitarian-context-handicap-international.pdf.

services; and the isolation of girls and young women with disabilities in institutions, camps, family homes or group homes. Moreover, many women and girls with disabilities report that their specific needs and expectations are not met by gynaecological services.[29]

26. Girls and young women with disabilities face unique challenges with regard to the management of menstrual hygiene. The absence of appropriate sanitation facilities in schools, including separate, accessible and sheltered toilets, in addition to the lack of education, resources and support for menstrual hygiene, compromise their ability to properly manage their hygiene and make them especially prone to diseases.[30] Consequently, many girls and young women with disabilities stay at home or are sent to special schools, reinforcing their exclusion from comprehensive sexuality education.

27. The prevalence of sexually transmitted infections among youth with disabilities, including girls and young women with disabilities, is of concern. Evidence shows that children and youth with disabilities have a similar or increased risk for contracting sexually transmitted infections compared with other youth, while girls with disabilities experience higher rates than boys with disabilities.[31] However, youth with disabilities, including girls, are less likely to receive information about the prevention of HIV/AIDS or to be given condoms or other methods to prevent sexually transmitted diseases. Evidence suggests, for example, that HIV testing is lower among youth with disabilities (men and women) than among the general population.[32] Generally, girls and young women with disabilities are not the target of prevention campaigns on sexually transmitted infections and cancers. The issue is particularly serious for those who are deaf or deaf-blind, who are traditionally excluded from all mainstream information.

28. The pervasive misconception that adolescents, both with and without disabilities, lack the capacity to make autonomous decisions about their own health care is a major barrier to girls and young women with and without disabilities when they attempt to access sexual and reproductive health information and services. Many States legally limit the ability of adolescents to make autonomous choices about their sexual and reproductive health and rights by requiring parental notification or consent prior to the provision of information and services, or by permitting health-care providers to deny reproductive health information, goods and services to adolescents. Moreover, for young women with disabilities over legal age, legislation restricting their legal capacity on the basis of disability and misconceptions about their perceived lack of capacity prevent many of them from making autonomous decisions about sexual and reproductive health-care services. Those restrictive circumstances result in an impenetrable barrier for girls and young women with disabilities, especially for those requiring support to express their will and preferences, since such support is usually provided by the family. Consequently, in many cases, girls and young women with disabilities have no control over their own sexual and

[29] F. Williams, G. Scott and A. McKechanie, "Sexual health services and support: the views of younger adults with intellectual disability", *Journal of Intellectual and Developmental Disability*, vol. 39, No. 2 (2014).

[30] OHCHR, "Realisation of the equal enjoyment of the right to education by every girl" (2017), p. 12. Available from www.ohchr.org/Documents/Issues/Women/WRGS/ReportGirlsEqualRightEducation.pdf.

[31] U. Agarwal and S. Muralidhar, "A situational analysis of sexual and reproductive health issues in physically challenged people, attending a tertiary care hospital in New Delhi", *Indian Journal of Sexually Transmitted Diseases*, vol. 37, No. 2 (July-December 2016); J. B. Munymana, V. R. P. M'kumbuzi, H. T. Mapira, I. Nzabanterura, I. Uwamariya and E. Shema, "Prevalence of HIV among people with physical disabilities in Rwanda", *Central African Journal of Medicine*, vol. 60, Nos. 9-12 (September-December 2014).

[32] T. J. Aderemi, M. Mac-Seing, S. A. Woreta and K. A. Mati, "Predictors of voluntary HIV counselling and testing services utilization among people with disabilities in Addis Ababa, Ethiopia", *AIDS Care*, vol. 26, No. 12 (2014); Y. Bat-Chava, D. Martin and J. G. Kosciw, "Barriers to HIV/AIDS knowledge and prevention among deaf and hard-of-hearing people", *AIDS Care*, vol. 17, No. 5 (July 2005).

reproductive lives, as decisions are taken for them under the paternalistic guise of "for their own good" (see A/67/227, para. 36). Denying access to sexual and reproductive health care to girls and young women with disabilities is a form of violence, which also exposes them to the risks of unwanted pregnancy, early marriage and school dropout.

C. Harmful and forced practices

29. The forced sterilization of girls and young women with disabilities represents a widespread human rights violation across the globe. Girls and young women with disabilities are disproportionately subjected to forced and involuntary sterilization for different reasons, including eugenics, menstrual management and pregnancy prevention.[13] Women with intellectual and psychosocial disabilities, as well as those placed in institutions, are particularly vulnerable to forced sterilization. Despite the limited data on current practices, studies show that the sterilization of women and girls with disabilities continues to be prevalent, and up to three times higher than the rate for the general population.[14]

30. While United Nations human rights instruments, mechanisms and agencies have recognized that the forced sterilization of persons with disabilities constitutes discrimination, a form of violence, torture and other cruel, inhuman or degrading treatment,[15] the practice is still legal and applied in many countries.[16] Across the globe, many legal systems allow judges, health-care professionals, family members and guardians to consent to sterilization procedures on behalf of persons with disabilities as being in their "best interest", particularly for girls with disabilities who are under the legal authority of their parents. The practices are often conducted on a purported precautionary basis because of the vulnerability of girls and young women with disabilities to sexual abuse, and under the fallacy that sterilization would enable girls and young women with disabilities who are "deemed unfit for parenthood" to improve their quality of life without the "burden" of a

[13] Open Society Foundations, Human Rights Watch, Women with Disabilities Australia and International Disability Alliance, "Sterilization of women and girls with disabilities: a briefing paper" (November 2011). Available from www.opensocietyfoundations.org/publications/sterilization-women-and-girls-disabilities-0.

[14] L. Servais, R. Leach, D. Jacques and J. P. Roussaux, "Sterilisation of intellectually disabled women", *European Psychiatry*, vol. 19, No. 7 (November 2004); L. Lennerhed, "Sterilisation on eugenic grounds in Europe in the 1930s: news in 1997 but why?", *Reproductive Health Matters*, vol. 5, No. 10 (November 1997).

[15] See Convention on the Rights of Persons with Disabilities, arts. 5, 12, 23 and 25, Committee on the Rights of Persons with Disabilities, general comment No. 3, paras. 10, 32, 44 and 45, Committee on Economic, Social and Cultural Rights, general comment No. 22, para. 30, Committee on the Rights of the Child, general comment No. 20, para. 31, Committee on the Rights of the Child, general comment No. 13, para. 23, CEDAW/C/CZE/CO/5, paras. 34-35, 37 and 42, CEDAW/C/AUL/CO/7, paras. 35 and 43, A/63/175, paras. 40-41 and 70-76, A/HRC/22/53, para. 48, A/67/227, para. 28, A/HRC/32/32, para. 94, and OHCHR, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the Joint United Nations Programme on HIV/AIDS, the United Nations Development Programme, the United Nations Population Fund, UNICEF and WHO, *Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement* (WHO, Geneva, 2014). Available from www.unaids.org/sites/default/files/media_asset/201405_sterilization_en.pdf.

[16] See the concluding observations of the Committee on the Rights of Persons with Disabilities in relation to the reports of Argentina, Australia, Bolivia (Plurinational State of), Brazil, Canada, Chile, Colombia, Costa Rica, the Cook Islands, Croatia, Czechia, China, the Dominican Republic, El Salvador, Germany, Honduras, Hungary, Iran (Islamic Republic of), Jordan, Kenya, Lithuania, Mauritius, Mexico, Mongolia, New Zealand, Peru, Portugal, Qatar, the Republic of Korea, the Republic of Moldova, Serbia, Slovakia, Spain, Thailand, Turkmenistan, Ukraine, Uruguay and the European Union.

pregnancy.[37] However, sterilization neither protects them against sexual violence or abuse nor removes the State's obligation to protect them from such abuse.[38] Forced sterilization is an unacceptable practice with lifelong consequences on the physical and mental integrity of girls and young women with disabilities that must be immediately eradicated and criminalized.

31. Other medical procedures or interventions that are often performed without the free and informed consent of girls and young women with disabilities include forced contraception and forced abortion. Contraception is often used to control menstruation at the request of health professionals or parents.[39] Moreover, while the contraceptive needs of girls and young women with disabilities are the same as those without disabilities, they receive contraception more often by way of injection or through intrauterine devices rather than orally, as it is less burdensome for families and service providers.[40] In addition, girls and young women with disabilities are frequently pressured to end their pregnancies owing to negative stereotypes about their parenting skills and eugenics-based concerns about giving birth to a child with disabilities.[41] During official country visits, the Special Rapporteur has received information about compulsory regular gynaecological checks and the use of forced abortion in institutions as a way to contain the institution's population.[42]

32. There is a worrisome and growing number of cases of surgical procedures and hormonal treatments intended to inhibit the growth of girls and young women with severe impairments. Hysterectomy, for example, is regarded as an effective way to avoid menstruation management,[42] and it is justified on the discriminatory presumption that girls and young women with disabilities cannot handle the pain, discomfort and trauma of menstruation — an argument not applicable to girls and women without disabilities. Oestrogen treatment is also being increasingly administered for "growth-attenuation therapy", aiming to inhibit girls' entry into puberty and reduce their final height and weight in order to facilitate care.[43] Those practices constitute gross human rights violations that go well beyond patronizing and infantilizing; they prioritize the interests of caregivers to the detriment and denial of a person's dignity and integrity. As the Committee on the Rights of the Child has emphasized, the interpretation of a child's best interests cannot be

[37] See, for example, the Constitutional Court of Colombia, sentence C-182 of 13 April 2016, and the Constitutional Court of Spain, sentence 215/1994 of 14 July 1994.

[38] OHCHR, et al., *Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement*, p. 6.

[39] H. M. J. Van Schrojenstein Lantman-de Valk, F. Rook and M. A. Maaskant, "The use of contraception by women with intellectual disabilities," *Journal of Intellectual Disability Research*, vol. 55, No. 4 (April 2011).

[40] M. McCarthy, "'I have the jab so I can't be blamed for getting pregnant': contraception and women with learning disabilities", *Women's Studies International Forum*, vol. 32, No. 3 (May-June 2009); M. Morad, I. Kandel and J. Merrick, "Residential care centers for persons with intellectual disability in Israel: trends in contraception methods 1999-2006", *Medical Science Monitor*, vol. 15, No. 6 (June 2009).

[41] J. O'Connor, "Literature review on provision of appropriate and accessible support to people with an intellectual disability who are experiencing crisis pregnancy", National Disability Authority (Údarás Náisúnta Míchumais). Available from http://crisispregnancy.ie/wp-content/uploads/2012/05/Literature-Review-on-Provision-of-Appropriate-and-AccessibleSupport-to-People-with-an-Intellectual-Disability-who-areExperiencing-Crisis-Pregnancy.pdf.

[42] L. Lin, J. Lin, C. M. Chu and L. Chen "Caregiver attitudes to gynaecological health of women with intellectual disability", *Journal of Intellectual and Developmental Disability*, vol. 36, No. 3 (September 2011); A. Albanese and N. Hopper, "Suppression of menstruation in adolescents with severe learning disabilities", *Archives of Disease in Childhood*, vol. 92, No. 7 (July 2007).

[43] A. Pollock, N. Fost and D. Allen, "Growth attenuation therapy: practice and perspectives of paediatric endocrinologists", *Archives of Disease in Childhood*, vol. 100, No. 12 (December 2015); N. Kerruish, "Growth attenuation therapy: views of parents of children with profound cognitive impairment", *Cambridge Quarterly of Healthcare Ethics*, vol. 25, No. 1 (January 2016).

used to justify practices that conflict with the child's human dignity and right to physical integrity.[44] Stunting a girl's growth does not represent, by any means, an appropriate response to the lack of support that families may encounter in providing assistance to their girls with disabilities.

33. Girls with disabilities are also likely to be proposed for marriage in regions and communities where child marriage occurs. Indeed, families are more prone to force girls with disabilities into marriage because they see it as a way to ensure long-term security and protection for their children.[45] In addition, the Committee on the Rights of Persons with Disabilities has strongly condemned the practice of female genital mutilation affecting girls and women with disabilities in a number of countries.[46]

D. Sexual and gender-based violence against girls and young women with disabilities

34. Girls and young women with disabilities are disproportionately affected by different forms of gender-based violence, including physical, sexual, psychological and emotional abuse; bullying; coercion; arbitrary deprivation of liberty; institutionalization; female infanticide; trafficking; neglect; domestic violence; and harmful practices such as child and forced marriage, female genital mutilation, forced sterilization and invasive and irreversible involuntary treatments (see A/HRC/20/5, paras. 12-27). Many of those forms of violence are a consequence of the intersection between disability and gender, and might happen while a girl or young woman with disabilities performs daily hygiene, receives treatment or is overmedicated. Gender-based violence occurs at home, in institutions, in schools, in health centres and in other public and private facilities, and perpetrators are frequently relatives, caregivers and professionals on whom the girl or young woman may depend.

35. Evidence on sexual and gender-based violence against girls and young women with disabilities is robust. Studies from across the globe show that they are at increased risk of violence, abuse and exploitation compared with those without disabilities, and with boys and young men with disabilities.[47] Overall, children with disabilities are almost four times more likely to experience violence than children without disabilities.[48] However, the risk is consistently higher in the case of deaf, blind and autistic girls, girls with psychosocial and intellectual disabilities and girls with multiple impairments.[49] Belonging to a racial, religious or sexual minority, or being poor, also increases the risk factor for sexual abuse for girls and young women with disabilities.[50] Humanitarian crises and conflict and post-

[44] See Committee on the Rights of the Child, general comment No. 13, para. 61.

[45] E. Shrestha, A. Singh, B. Maya and P. Kuyu, *Uncovered realities: Exploring experiences of child marriage among children with disabilities* (Plan International Norway, 2017).

[46] See CRPD/C/GAB/CO/1, paras. 40-41, CRPD/C/KEN/CO/1, paras. 33-34, CRPD/C/ETH/CO/1, paras. 39-40 and CRPD/C/UGA/CO/1, paras. 34-35.

[47] E. A. Davies and A. C. Jones, "Risk factors in child sexual abuse", *Journal of Forensic and Legal Medicine*, vol. 20, No. 3 (April 2013); K. M. Devries, N. Kyegombe, M. Zuurmond, J. Parkes, J. C. Child, E. J. Walakira, et al., "Violence against primary school children with disabilities in Uganda: a cross-sectional study", *BMC Public Health*, vol. 14, No. 1 (September 2014); I. Hershkowitz, M. E. Lamb and D. Horowitz, "Victimization of children with disabilities", *American Journal of Orthopsychiatry*, vol. 77, No. 4 (October 2007).

[48] Lisa Jones, et al., "Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies", *The Lancet*, vol. 380, No. 9845 (July 2012).

[49] E. Brunnberg, et al., "Sexuality of 15/16-year-old girls and boys with and without modest disabilities"; S. J. Caldas and M. L. Benoy, "The sexual maltreatment of students with disabilities in American school settings", *Journal of Child Sexual Abuse*, vol. 23, No. 4 (2014).

[50] S. L. Martin, N. Ray, D. Sotres-Alvarez, L. L. Kupper, K. E. Moracco, P. A. Dickens, et al., "Physical and sexual assault of women with disabilities", *Violence Against Women*, vol. 12, No. 9 (September 2006).

conflict settings generate additional risks of sexual violence and trafficking that affect girls with disabilities.

36. Girls and young women with disabilities also encounter significant challenges when attempting to access justice, prevention mechanisms and response services for sexual and gender-based violence. Sexual assault is often underreported, and even more so when the individual has a disability.[51] Girls and young women with disabilities face numerous challenges when reporting abuses, such as the risk of being removed from their homes and institutionalized; stigmatization; fears with regard to single parenthood or losing child custody; the absence or inaccessibility of violence prevention programmes and facilities; the fear of the loss of assistive devices and other supports; and the fear of retaliation and further violence by those on whom they are both emotionally and financially dependent (see A/67/227, para. 59). In addition, when, as survivors of sexual violence, they report the abuse or seek assistance or protection from judicial or law enforcement officials, teachers, health professionals, social workers or others, their testimony, especially that of girls and women with intellectual disabilities, is generally not considered credible, and they are therefore disregarded as competent witnesses, resulting in perpetrators avoiding prosecution.[52]

37. Physical and communication barriers in the justice system hinder access to justice by girls and young women with disabilities and their ability to seek and obtain redress. The barriers include lack of accessibility and reasonable and procedural accommodations, such as sign language interpretation, alternative forms of communication and support services that are age- and gender-sensitive. For example, the lack of provision of sign language interpretation can significantly limit the chances of success of deaf applicants. Moreover, owing to prejudices and stereotypes, courts commonly discount the testimony of girls and young women with disabilities in sexual assault cases, from questioning whether girls and young women with intellectual disabilities can understand the oath when testifying to discrediting the testimony of blind witnesses because they are not "able" to know/perceive the sequence of events. Courts often also fail to develop child-friendly proceedings adapted to the particular circumstances of girls with disabilities, including the provision and delivery of gender-sensitive and child-friendly information.[53]

IV. Implementing sexual and reproductive health and rights of girls and young women with disabilities

38. States can take a number of measures to improve sexual and reproductive health and rights of girls and young women with disabilities, including by reviewing their legal and policy frameworks; taking concrete measures in the areas of education and information, access to justice, accessibility, non-discrimination and participation; and by allocating specific budgets for their implementation.

A. Legal framework

39. States must ensure a supportive legislative and regulatory framework for the sexual and reproductive health and rights of girls and young women with disabilities. Existing general laws and regulations that restrict the free access of girls and women to sexual and

[51] I. Hershkowitz, et al., "Victimization of children with disabilities".

[52] B. L. Bottoms, K. L. Nysse-Carris, T. Harris and K. Tyda, "Jurors' perceptions of adolescent sexual assault victims who have intellectual disabilities", *Law and Human Behavior*, vol. 27, No. 2 (April 2003).

[53] See Committee on the Rights of Persons with Disabilities, general comment No. 3, para. 52, and Committee on the Rights of the Child, general comment No. 12 (2009) on the right of the child to be heard, paras. 32-34.

reproductive health services, including by requiring spousal or parental consent or setting a minimum age, should be amended to facilitate universal and equitable access to sexual and reproductive health information and services.[54] Narrow definitions of sexual violence, including sexual assault and rape, should be reviewed to include all forms of violence experienced by girls and young women with disabilities.

40. States must immediately repeal all legislation and regulatory provisions that allow the administration of contraceptives to and the performance of abortion, sterilization or other surgical procedures on girls and young women with disabilities without their free and informed consent, and/or when decided by a third party. Furthermore, States should consider adopting protocols to regulate and request the free and informed consent of girls and young women with disabilities with regard to all medical procedures. Colombia, for example, recently adopted regulations for the delivery of sexual and reproductive health services to persons with disabilities, which include references to the provision of reasonable accommodation and support in decision-making.[55] Laws permitting substituted decision-making and involuntary treatment of persons with disabilities must also be revoked.

B. Policy framework

41. The rights of and needs of girls and young women with disabilities must be mainstreamed and addressed by States in all policies and programmes on sexual and reproductive health and rights. Many States have a range of policies and strategies that specifically address both the rights of persons with disabilities and sexual and reproductive health and rights, but those are usually disconnected and do not include a child, youth or gender perspective. Moreover, where policies and strategies identify persons with disabilities as key vulnerable groups, there is generally little focus on the specific challenges faced by girls and young women with disabilities. States must ensure that their health-care systems and services meet the specific sexual and reproductive health needs of adolescents with disabilities.

42. Sexual and reproductive health care must be provided for free or at an affordable cost to all girls and young women with disabilities, including access to products and medicines.[56] Universal health coverage can increase their access to quality sexual and reproductive health care. Social protection systems also help to address the additional costs that girls and young women with disabilities face when accessing sexual and reproductive health care, and to facilitate support services for those who might need it (see A/70/297, paras. 4-9, and A/HRC/34/58, para. 68). States must also ensure that girls and young women with disabilities benefit from the same range and quality of sexual and reproductive health services and programmes as other women and girls.[57]

43. States must ensure that sexual and reproductive health care is provided as close as possible to the communities where girls and women with disabilities live.[58] Distance from/to health-care facilities in rural and remote areas constitutes a significant barrier to persons with disabilities owing to poverty, the absence of accessible and affordable transport and the lack of support. States must ensure that their rural development strategies include measures to promote access to quality sexual and reproductive health care for girls

[54] See Committee on Economic, Social and Cultural Rights, general comment No. 22, para. 44, Committee on the Rights of the Child, general comment No. 15, para. 31, and A/54/38/Rev.1, para. 14.

[55] Ministry of Health and Social Protection of Colombia, resolution 1904, 31 May 2017.

[56] See Committee on Economic, Social and Cultural Rights, general comment No. 22, para. 17.

[57] Ibid., para. 24.

[58] See Convention on the Rights of Persons with Disabilities, art. 25.

and women with disabilities, including community-based strategies and outreach services (e.g., mobile clinics, health caravans, telemedicine and phone-based strategies).

C. Education

44. States need to provide comprehensive and non-discriminatory sexuality education to girls and young women with disabilities, both within and outside school (see A/65/162, paras. 62 and 87). It should include information about self-esteem and healthy relationships; sexual and reproductive health, contraception and sexually transmitted diseases; the prevention of sexual and other forms of exploitation, violence and abuse; stigma and prejudices against persons with disabilities; gender roles; and human rights. Indeed, sexuality education has been found to be effective in improving the sexual knowledge and skills of youth with disabilities, and in reducing sexual violence against them.[59] States must ensure that their sexuality education programmes are inclusive of girls and young women with disabilities and their specific needs, and that they are made available in accessible and alternative communication formats. Peer-education programmes are effective ways to enhance knowledge and skills with regard to the sexual and reproductive health and rights of girls and young women with disabilities.

45. States should train health-care personnel, teachers, community workers and other public officials on the sexual and reproductive health and rights of girls and young women with disabilities. All primary health-care workers dealing with sexual and reproductive health, particularly in rural and remote areas, must be adequately trained, prepared and supported in their work.[60] For example, in Guwahati, India, a team of service providers was trained to provide support to young persons with disabilities with regard to accessing sexual and reproductive health and rights information and services and identifying sexually abusive behaviours. The adoption of technical guidelines on how to provide adequate sexual and reproductive health and rights information and services to girls and young women with disabilities is recommended. In Uruguay, for example, the government developed a guide on sexual and reproductive health and rights of persons with disabilities that has been distributed to all health centres across the country.

46. States must provide information and assistance to families of girls and young women with disabilities in relation to sexual and reproductive health and rights. Families may need assistance in understanding their child's sexuality, ways to support their sexual and reproductive health needs and ways to avoid, recognize and report instances of sexual exploitation, violence and abuse. Studies have shown that training can change the attitudes of parents towards the sexuality of their children with disabilities and improve their confidence in talking to them about sexuality.[61] Parents and family members need guidance on understanding the importance of sexuality education and respecting their children's right to express their views freely, which will help them overcome fears about the risk of sexual exploitation and abuse of girls and young women with disabilities. Families should be involved not just as recipients of training but as participants of awareness-raising initiatives to modify their own attitudes and practices in relation to their children with disabilities.

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[59] J. Duh, "Sexual knowledge of Taiwanese adolescents with and without visual impairments"; S. Altundağ and N. Ç. Çalbayram, "Teaching menstrual care skills to intellectually disabled female students".

[60] WHO, *Sexual and reproductive health core competencies in primary health care* (Geneva, 2011).

[61] K. Clatos and M. Asare, "Sexuality education intervention for parents of children with disabilities: a pilot training program", *American Journal of Health Studies*, vol. 31, No. 3 (June 2016); G. Yildiz and A. Cavkaytar, "Effectiveness of a sexual education program for mothers of young adults with intellectual disabilities on mothers' attitudes toward sexual education and the perception of social support", *Sexuality and Disability*, vol. 35, No. 1 (March 2017).

D. Access to justice

47. States must ensure effective access to justice for girls and young women with disabilities who experience sexual and other forms of violence. Access to effective and accessible judicial and other appropriate remedies is critical to combating all forms of exploitation, violence or abuse against girls and young women with disabilities in the public and private spheres. States must eliminate all restrictions preventing girls and young women with disabilities from accessing justice, including restrictive rules on legal standing on the basis of age and disability.

48. States need to take all appropriate legislative, administrative and other measures necessary to ensure the provision of procedural and age-appropriate accommodations for girls and young women with disabilities, which is essential to enabling their effective direct and indirect participation, including as witnesses, in all legal proceedings, from investigative and other preliminary stages to court hearings. All protection services must be age-, gender- and disability-sensitive.[62] For instance, the Kenya Association for the Intellectually Handicapped provides training to law enforcement officials, health personnel and service providers on the provision of reasonable and procedural accommodations to persons with intellectual disabilities and on respect for their personal autonomy.

49. States have an obligation to prevent, investigate, prosecute and try all acts of violence, including sexual violence, and to protect the rights and interests of the victims.[63] National human rights institutions and civil society organizations can play a key role in carrying out inquiries and investigations on exploitation, violence or abuse against girls and young women with disabilities, and in assisting all women with disabilities in accessing legal remedies. For instance, the National Union of Women with Disabilities of Uganda trained 32 women with disabilities as paralegals with knowledge about the rights of women and girls with disabilities related to sexual and reproductive health and rights and gender-based violence. The paralegals offer peer-to-peer support with regard to reporting violations and conducting the necessary follow-up to ensure justice is achieved. States should consider reparations and redress mechanisms for girls and young women with disabilities who have been subjected to harmful practices, such as forced sterilization and forced abortion, particularly within institutions (see CEDAW/C/JPN/CO/7-8, paras. 24-25).

E. Accessibility

50. States must ensure the full accessibility of all sexual and reproductive health and rights information and services. All public and private facilities and services open or provided to the public, including gynaecological and obstetric services, must take into account all aspects of accessibility for women with disabilities, including accessibility with regard to infrastructure, equipment and information and communications. Transport to reach those services must be accessible, as otherwise girls and young women with disabilities will continue to be obstructed from enjoying and exercising their sexual and reproductive health rights in practice.[64]

51. States must ensure that all information and communication pertaining to sexual and reproductive health and rights are accessible to persons with disabilities, including through sign language, Braille, accessible electronic formats, alternative script, easy-to-read formats, and augmentative and alternative modes, means and formats of communication.[64] For instance, call centres to report cases of gender-based violence must be accessible to

[62] See Convention on the Rights of Persons with Disabilities, art. 16.

[63] See Committee on Economic, Social and Cultural Rights, general comment No. 22, para. 64.

[64] See Committee on the Rights of Persons with Disabilities, general comment No. 2 (2014) on article 9: accessibility, para. 40.

deaf and hard-of-hearing girls and women through text messaging or other alternative methods. For example, Illinois Imagines has developed guides and other materials for rape crisis centres, disability service agencies and self-advocates that include guidance for prevention education programmes and picture guides about sexual assault exams and the rights of sexual violence survivors.[65] The University of Tartu in Estonia has provided training for teachers on how to deliver comprehensive sexuality education in plain language so that children with intellectual disabilities can benefit equally from the lessons.

F. Non-discrimination

52. States have an obligation to provide access to sexual and reproductive health and rights services to all girls and young women with disabilities without discrimination. States must therefore eliminate discrimination against girls and young women with disabilities in law, policy and practice; ensure child- and gender-sensitive policies and programmes; and prohibit all forms of discrimination in the provision of those services. Moreover, States need to take measures to provide disability- and age-appropriate support and reasonable accommodation to girls and young women with disabilities so that they can access and enjoy those services and facilities on an equal basis with others.

53. States must recognize the existing layers of identities within the disability community in order to adequately address the inequalities and intersectional discrimination experienced by girls and young women with disabilities. States should consider developing and implementing policies and practices targeting the most marginalized groups of girls and young women with disabilities (e.g., those with multiple or severe impairments and deaf-blind girls and young women) in order to accelerate or achieve de facto equality.

G. Participation

54. States must consult and involve children with disabilities, including girls and adolescents, in the implementation of sexual and reproductive health and rights as provided by articles 4, paragraph 3, and 7 of the Convention on the Rights of Persons with Disabilities. It is crucial that girls and young women with disabilities be consulted, as they are the experts on their own lives. Girls and young women with disabilities, even the youngest, have the right to participate in policymaking, so they must be provided with disability- and age-appropriate support. Plan International has developed guidelines for consulting with children and young people with disabilities that contain practical suggestions on the matter.[66]

55. States should be aware that the views of girls and young women with disabilities might collide with those of their families and caregivers. While organizations of parents of children with disabilities are instrumental in promoting and securing the autonomy and active participation of their children, States must always take into consideration the will and preferences of children with disabilities (see A/HRC/31/62, para. 36). Similarly, mainstream organizations of persons with disabilities might have different views from those of children with disabilities, therefore it is important to consult and engage directly with girls and adolescents with disabilities.

[65] See Illinois Imagines, "Materials — toolkit and other material". Available from www.icasa.org/index.aspx?PageID=1045.

[66] Plan International, "Guidelines for consulting with children and young people with disabilities". Available from https://plan-international.org/publications/guidelines-consulting-children-and-young-people-disabilities.

H. Data collection

56. States must collect appropriate information, including statistical and research data, to formulate and implement disability-inclusive sexual and reproductive health and rights policies and programmes and monitor and evaluate progress in promoting and protecting the rights of girls and young women with disabilities.[67] The lack of reliable and comparable statistical data on sexual and reproductive health and rights of girls and young women with disabilities is alarming, particularly in middle- and low-income countries. Academic literature on the sexual and reproductive health and rights of girls with disabilities is also scant and tends to focus on self-reported experiences and challenges rather than on positive interventions.[68] In this regard, the Special Rapporteur welcomes the upcoming United Nations Population Fund global study on the sexual and reproductive health and rights of young people with disabilities, which will also cover gender-based violence.

57. The Sustainable Development Goals, which call for a significant increase in the availability of high-quality, timely and reliable data disaggregated by, inter alia, gender, age and disability (Goal 17), represent a unique opportunity to collect better data related to the sexual and reproductive health and rights of girls and young women with disabilities. The short set of six questions on disability formulated by the Washington Group on Disability Statistics provides a well-tested method for disability data disaggregation in national censuses and surveys, including household and demographic and health surveys. In addition, the United Nations Children's Fund (UNICEF) and the Washington Group on Disability Statistics have developed a module on child functioning, which covers children between the ages of 2 and 17 that can be incorporated into existing data collection efforts.[69] The module is included in the current round of the UNICEF-supported multiple indicator cluster survey that will be implemented in more than 35 low- and middle-income countries during the next three years.[70]

I. Resource mobilization

58. States have an obligation to take immediate steps to the maximum of their available resources, including those made available through international cooperation, to ensure that girls and young women with disabilities can fully exercise their sexual and reproductive rights and access quality sexual and reproductive health services.[71] Government plans and budgets must incorporate sexual and reproductive health and rights policies and strategies and consider the particular needs of girls and young women with disabilities. Participatory budgeting processes and earmarked funds can help expand the allocation of public funds in that area. States should regularly monitor whether or not the resources available were used

[67] See Convention on the Rights of Persons with Disabilities, art. 31.

[68] S. Hellum Braathen, P. Rohleder and G. Azalde, "Sexual and reproductive health and rights of girls with disabilities: a review of the literature", SINTEF Technology and Society, 2017. Available from www.sintef.no/globalassets/sintef-teknologi-og-samfunn/en-sintef-teknologi-og-samfunn/2017-00083_report-sintef-uel-literature-review-srhr-girls-disability-with-appendices.pdf.

[69] UNICEF, "A new way to measure child functioning". Available from https://data.unicef.org/topic/child-disability/module-on-child-functioning.

[70] The Demographic and Health Surveys Program of the United States Agency for International Development has recently developed a new disability module based on the Washington Group on Disability Statistics' short set of questions, which can be inserted into household questionnaires to collect data on disability for all persons in the household aged 5 and above. Available from http://dhsprogram.com/Who-We-Are/News-Room/Collaboration-yields-new-disability-questionnaire-module.cfm.

[71] See Committee on the Rights of the Child, general comment No. 19 (2016) on public budgeting for the realization of children's rights, paras. 28-33.

to progressively achieve the full realization of the sexual and reproductive health rights of girls and young women with disabilities.

59. The Sustainable Development Goals, which contain specific targets and references to sexual and reproductive health and rights and to persons with disabilities, constitute an excellent opportunity to achieve a coordinated engagement of international donors to advance the sexual and reproductive health and rights of girls and young women with disabilities. According to article 32, paragraph 1 (a), of the Convention on the Rights of Persons with Disabilities, international donors must ensure that all international cooperation, including international development programmes in the area of sexual and reproductive health and rights, is inclusive of and fully accessible to persons with disabilities.

V. Conclusions and recommendations

60. **Girls and young women with disabilities have the same sexual and reproductive health and rights as other girls and young women. However they encounter significant obstacles in exercising and accessing those rights, including stigma and stereotypes, restrictive legislation and a lack of child- and disability-appropriate information and services. Moreover, poverty and/or social exclusion deprive them of the necessary knowledge to develop healthy relationships and increase the risk of sexual abuse, sexually transmitted diseases, unintended pregnancies and harmful practices. Grave human rights violations such as forced sterilization, forced abortion and forced contraception are frequent, and the violence experienced by girls and young women with disabilities remains largely invisible.**

61. **The lack of attention to the above-mentioned situations puts those girls and women in grave danger. States have the power to stop that from happening by establishing legal and policy frameworks that recognize and protect the sexual and reproductive health and rights of girls and young women with disabilities by ending all involuntary and harmful practices affecting them. Moreover, States must support the process of empowerment of those young women and girls to enable them to make autonomous decisions about their sexual and reproductive lives. The attitudes and practices of health-care professionals, service providers, teachers and families must also be revised in line with international human rights standards, as in many cases their responses limit the full enjoyment of rights by girls and young women with disabilities.**

62. **The Special Rapporteur makes the following recommendations to States:**

(a) **Recognize by law the sexual and reproductive health and rights of girls and young women with disabilities, and remove all legal barriers that prevent them from accessing sexual and reproductive health information, goods and services, including legislation that limits their right to make autonomous decisions;**

(b) **Prohibit by law the forced sterilization of girls and young women with disabilities, as well as other compulsory or involuntary practices affecting their sexual and reproductive health and rights, and ensure adequate procedural safeguards to protect their right to free and informed consent;**

(c) **Mainstream the rights of girls and young women with disabilities in all sexual and reproductive health and rights strategies and action plans to ensure that all sexual and reproductive health information, goods and services are accessible and age-, gender- and disability-sensitive;**

(d) **Ensure that sexual and reproductive health services are respectful of the rights of girls and young women with disabilities, including their right to**

non-discrimination, informed consent prior to being subjected to any medical treatment, privacy and freedom from torture or other cruel, inhuman or degrading treatment;

(e) Design and implement comprehensive inclusive and accessible sexuality education programmes and materials for girls and young women with disabilities within and outside the school system;

(f) Ensure that services and programmes aimed at protecting women and girls from violence, including police stations, shelters and courts, are inclusive of and accessible to girls and young women with disabilities;

(g) Provide adequate training to law enforcement officials, prosecutors and judges on how to protect girls and young women with disabilities from violence;

(h) Encourage and support the effective independent monitoring by national human rights institutions or other independent bodies of all public and private facilities and programmes that provide services to persons with disabilities, prevent all forms of exploitation, violence and abuse and take action when human rights violations are encountered;

(i) Implement awareness-raising programmes designed to change the societal perception of the sexual and reproductive health and rights of girls and young women with disabilities and end all forms of violence against them, including forced sterilization, forced abortion and forced contraception;

(j) Support families, including through the provision of information, education and services, in strengthening their ability to understand and address the sexual and reproductive health and rights of girls and young women with disabilities, free from stigma and stereotypes;

(k) Adopt strategies to ensure the direct participation of girls and young women with disabilities in all processes of public decision-making related to sexual and reproductive health and rights, including the development of legislative or policy measures regarding sexual and gender-based violence and other forms of abuse, and guarantee that such participation is conducted in a safe environment with age- and disability-appropriate support;

(l) Collect information, including statistical and research data, on the sexual and reproductive health and rights of girls and young women with disabilities, including with regard to harmful practices and all forms of violence, disaggregated by sex, age and disability;

(m) Mobilize resources within the framework of the Sustainable Development Goals and invest in inclusive programmes that increase the access of girls and young women with disabilities to sexual and reproductive health and rights.

63. The Special Rapporteur recommends that the United Nations, including all its programmes, funds and specialized agencies, adequately consider the sexual and reproductive health and rights of girls and young women with disabilities in all its work, including when assisting States in the implementation of mainstream policies and programmes.